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## **A Qualitative Thematic Review: Emotional Labour in Healthcare Settings**

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## **Abstract**

**Aims:** To identify the range of emotional labour employed by healthcare professionals in a healthcare setting and implications of this for staff and organisations.

**Background:** In a health care setting, emotional labour is the act or skill involved in the caring role, in recognising the emotions of others and in managing our own.

**Design:** A thematic synthesis of qualitative studies which included emotion work theory in their design, employed qualitative methods and were situated in a health care setting. The reporting of the review was informed by the ENTREQ framework.

**Data Sources:** 6 databases were searched between 1979 and 2014

**Review Methods:** Studies were included if they were qualitative, employed emotion work theory and were written in English. Papers were appraised and themes identified. Thirteen papers were included.

**Results:** The reviewed studies identified four key themes: 1) The professionalisation of emotion and gendered aspects of emotional labour 2) Intrapersonal aspects of emotional labour – how healthcare workers manage their own emotions in the workplace 3) Collegial and organisational sources of emotional labour 4) Support and training needs of professionals

**Conclusion:** This review identified gendered, personal, organisational, collegial and socio-cultural sources of and barriers to emotional labour in healthcare settings. The review highlights the importance of ensuring emotional labour is recognised and valued, ensuring support and supervision is in place to enable staff to cope with the varied emotional demands of their work.

**Keywords:** thematic review, qualitative, emotional labour, emotion work, nurses, midwives, paramedics, doctors, medical students, care assistants

## **Summary Statement**

### **Why is this research or review needed?**

- No qualitative review of emotional labour in a healthcare setting has been undertaken to date.
- To gain a better understanding of the range of emotional labour undertaken in a health care setting and identify gaps in the literature.
- To gain insight into the sources of emotional labour to inform support and training needs.

### **What are the key findings?**

- The review identifies gendered, personal, organisational, collegial and socio-cultural sources of and barriers to emotional labour.
- The review indicates that health care staff resist organisational systems which devalue their emotion work, suggesting that feelings cannot always be ‘bought’ or ‘owned’.
- The review found that the employment of emotional labour was frequently hidden, taken-for-granted and undervalued.

### **How should the findings be used to influence policy/practice/research/education?**

- To inform the training offered to healthcare professionals regarding the gendered, personal, professional and cultural sources of emotional labour in the workplace.

- To raise awareness of the varying sources of emotional labour to colleagues and managers to ensure staff feel valued and supported.
- To ensure healthcare staff are provided with support and supervision to enable them to effectively manage the varied emotional demands of their work.

## **INTRODUCTION**

Contemporary health care has long advocated a patient-centred and holistic approach across the professional disciplines. These approaches recognise the value of caring and enactment of key skills such as compassion and empathy during healthcare encounters (Engel 1977, Kleinmann 1998). It is also recognised that the art and act of caring be regarded as work since it requires skills and resources to care (Smith 2012). Research in this area has employed the sociological lens of ‘emotion work’ to understand, de-construct and explore the work of caring and how it is employed in healthcare settings (Smith 2012, Theodosius 2006, Hochschild 1983).

### **Background**

Hochschild (1983) defined emotion work as the effort we invest in managing our own emotions and those of others, particularly the way individuals manage both their inner and outward feelings. In a health care setting, emotion work has been defined as the act or skill involved in the caring role and in recognising the emotions of others (Smith 2012). Hochschild's theory posited that in an organisational setting, workers' emotions can be commodified (bought or owned) as workers are expected to act and feel in ways which meet organisational demands.

Emotional labour theory is underpinned by Marxist theory, which challenges the commodification of feelings in an organisational setting and adopts a critical stance to the way workers' feelings can be manipulated or exploited for financial gain (Hochschild 2003). Emotion work theory is also underpinned by feminist theory, which critiques assumptions in relation to gendered emotional labour with expectations that caring or emotion work is 'women's work' (Hochschild 2003).

Hochschild argued that for workers to meet institutional demands, there is often a cost to the worker in the way it 'affects the degree to which we listen to feelings and sometimes our very capacity to feel' (Hochschild 1983 p. 21). Hochschild argued that stress can arise from having to act in ways we do not feel; such conflicting beliefs, attitudes or behaviour has been termed cognitive dissonance (Festinger 1957). Cognitive dissonance has been identified as a major contributing factor in stress and burnout in healthcare professionals who continually manipulate their emotions and perform in ways which do not reflect how they actually feel to cope with the emotional demands and expectations of their job (Zapf & Holz 2006).

It is, therefore, useful to identify the sources of emotional labour in contemporary health and social care settings to inform the provision of support and training to enable healthcare professionals to cope with the varying emotional requirements of their job. This paper

reports the findings of a qualitative thematic synthesis of emotional labour employed in healthcare settings. Our conclusions highlight the importance of ensuring emotional labour is recognised and valued, ensuring support and supervision is in place to enable health care staff to cope with the varied emotional demands of their work.

Hochschild differentiated emotion work undertaken in private and organisational settings. According to Hochschild, emotion ‘work’ is undertaken in an individual’s private sphere in contrast to emotional ‘labour’ which is work undertaken in an organisational setting (Hochschild 1983, 2003). In the individual’s private sphere, individuals offer emotional ‘gifts’ – offered freely with no expectation of reciprocity. In contrast, in an organisational setting, workers’ emotions can be commodified as workers are expected to act and feel in ways which meet organisational demands. Hochschild (1983, 2003).

Emotion work theory (Hochschild 2003, 1983) acknowledges that what we feel and what is communicated is influenced by socially constructed ‘feeling rules’ which govern what feelings or emotions can be felt or displayed in any given social context. Hochschild suggested that when emotions are managed in this way and that, when ‘on stage’ performing, we do not always show what we feel or feel what we show. In any given social context, individuals engage in ‘surface’ or ‘deep’ acting to manage their emotions by suppressing or manipulating them to present a socially acceptable or expected self-image (Hochschild 2003, 1983).

This aim of this review was to identify and critically review the sources of emotional labour in contemporary health and social care settings and identify the implications of this for staff and organisations in terms of support and training requirements. The review methodology employed a qualitative thematic synthesis of 13 papers meeting the inclusion criteria (see below) and is underpinned by a critical realist perspective. The reporting of the review methodology was guided by the ‘enhancing transparency in reporting the synthesis of



qualitative research' (ENTREQ) statement (Tong *et al.* 2012). The two reviewers possess both methodological and interdisciplinary backgrounds (qualitative methods, social science, medical sociology and pharmacy).

## **The Review**

### **Aims**

The aim of the review was to identify and critically reflect on the range of emotional labour employed by healthcare professionals in a health care setting and the implications of this for staff and organisations. A healthcare setting refers to acute, ambulatory, primary and secondary healthcare settings, including hospitals, emergency care and care homes. The review sets out to identify what research has been undertaken in this area; what methods have been used to capture and examine emotional labour in a healthcare context; what is known in the literature, its contribution to emotion work theory in a healthcare context; and potential gaps in research undertaken to date.

### **Design**

A thematic synthesis was undertaken using review methods informed by Ring *et al.* (2011). The review methodology is underpinned by a critical realist perspective which holds that 'knowledge of reality is mediated by one's beliefs and perspectives' (Tong *et al.* 2012 p.5). The reporting of the review methodology has been informed by the framework identified in the ENTREQ statement (Tong *et al.* 2012).

### **Search Methods**

#### *Sampling*

Systematic searches were conducted in PubMed, International Bibliography of the Social Sciences (IBSS), PsychInfo, Embase, CINAHL and Web of Science databases. The following search terms were employed in combined searches: emotion work, emotional labour, emotion management AND health care or health OR nurses, midwives, paramedics, doctors, health professionals, healthcare professionals, staff, workers, care assistants. The search identified relevant articles between January 1979 (the date of Hochschild's first paper) and September 2014. This identified 10 relevant papers. A cited author search in Web of Knowledge, using key papers by Hochschild (1979, 1983) who conceptualised the theory of emotional labour, identified a further three papers.

#### *Inclusion/exclusion criteria*

The search was restricted to the following: papers in English, original research (not discussion/conference papers or secondary analysis); qualitative research employing qualitative analysis; and use of emotional labour or emotion work as a stated theoretical perspective or as a focus of the research – as referred to in the abstract, introduction or methodology section.

#### **Search Outcome**

Initial searches identified 165 studies which were screened for relevance. A flow diagram detailing the results and selection of papers from the systematic search is presented in Figure 1. Thirteen articles met the inclusion criteria (see Table 1). The themes identified in the review are discussed in depth in the results section. The identified studies took place in the UK (N=9), USA (N=2), Canada (N=1), and Australia (N=1).

#### *Study design*

Of the 13 articles identified, the majority (N=9) combined ethnographic methods including observational methods, semi-structured or/and in-depth interviews or reflective audio

diaries. Seven studies employed a combination of participant or non-participant observation and one other method - audio diaries, semi-structured interviews, in-depth interviews or focus groups. Two studies employed observational methods and both interviews and focus groups. Four studies employed singular methods, using semi-structured interviews, in-depth interviews or focus groups.

### **Quality appraisal**

The principle author (RR) summarised the characteristics of each study to provide contextual information on author, date, country, study design, method of analysis. The aim/objectives of the study and evidence of reflexivity were recorded and entered into a table (Table 1). The principal author (RR) appraised all 13 articles while MW reviewed and coded a sub-sample of included papers (N=3). In cases where discrepancies were identified, agreement was achieved through discussion.

For those 13 studies meeting the search criteria, the methodology, findings and discussion sections of the papers were reviewed using qualitative assessment criteria outlined previously (Balaam *et al.* 2013, Walsh & Downe 2006). This assessment criteria included appraisal of the scope and purpose of the study, methodology (sampling, suitability of methods, transparency of the analytic process), credibility of reported findings, relevance/transferability of the findings, and evidence of reflexivity. The 'limitations' column in Table 1 summarises any weaknesses as identified during the appraisal process.

### **Data Abstraction and synthesis**

RR read each paper several times and undertook manual, line-by-line coding of the text using free codes annotated in the margins of the paper. The coding was undertaken inductively, where new and emerging codes were continually compared and contrasted and

reoccurring and emerging codes were noted. The free codes generated from the manual coding were subsequently organised into descriptive themes. The second author (MW) repeated this process for a sub-sample (N=3) of the papers. When open coding was complete and descriptive codes generated from all 13 papers, both authors discussed and critically interpreted the descriptive themes to further develop analytical themes. Key comments regarding the limitations of each study using the criteria (Balaam *et al.* 2013, Walsh & Downe 2006) were entered into table 1 under the heading limitations. The synthesised themes and their application to emotion work theory will be reviewed in the results section.

## **Review Findings**

The reviewed studies (N=13) employed a range of qualitative methods to explore emotional labour by healthcare professionals. The focus of these studies was on the more intrapersonal aspects of emotional labour theory, which observe or invite professionals to reflect on the meanings, challenges and positive aspects of emotional labour and emotion self-management.

The focus of emotional labour research varied across the studies but the thematic review identified the following four themes in the context of healthcare settings:

1. The professionalisation of emotion and gendered aspects of emotional labour - who is expected to employ emotional labour and a critique of emotion work as 'women's work'
2. Intrapersonal aspects of emotional labour – how healthcare workers manage their own emotions in the workplace

3. Collegial and organisational sources of emotional labour – how emotional labour is employed to support relationships and manage conflicts with colleagues and organisational hierarchy
4. Support and training needs of professionals – identifying the importance of support and training in enabling professionals to manage their emotions and those of others (patients, families and colleagues)

### **The Professionalisation of Emotion and Gendered Aspects of Emotional Labour**

This theme relates to socio-cultural expectations around the professionalization of emotions and assumptions about the employment (or not) of emotional labour. Half of the identified studies focused on the nursing professions: six studies focused on nurses in a hospital setting (Miller et al. 2008, Gray & Smith 2006, Theodosius 2006, Bolton 2000, Gattuso & Bevan 2000); two papers focused on midwives (Hunter 2005, Hunter 2004); two papers focused on paramedic students (Williams 2013a, Hunter 2013b); one study on medical students (Smith & Kleinman 1989); one study on National Health Service (NHS) Direct staff who included nurses (Weir & Waddington 2008) and one paper on healthcare assistants in care homes (Rodriquez 2011). The predominance of nurse-focused research is useful to reflect on, perhaps as Bolton suggests, because nurses are perceived as being a caring profession whose work involves a significant amount of emotional labour (Bolton 2001). It is not clear from those studies identified whether the focus on the nursing and midwifery professions reflects the interests of researchers, many of whom have a nursing background. The focus may also reflect wider societal or cultural expectations relating to gendered aspects of emotional labour and professions such as nursing and midwifery who are still largely occupied by women (Ball & Pike 2009).

The gendered aspects of emotional labour and critique of emotion work as women's work, questions assumptions about women as 'natural carers' (Gray & Smith 2009, Gattuso & Bevan 2000). Gray and Smith (2009), for instance, observed that gender stereotypes often meant that female nurses were perceived as 'invisible carers' whose caring ability was seen as natural because they were women. Male nurses, on the other hand, were often perceived as 'forgotten carers' who were constrained by societal rules and expectations relating to intimacy and distance. This included assumptions about whether it would be more acceptable for a female nurse to touch a patient compared with a male nurse (Gray & Smith 2009).

The theme relating to gendered aspects of emotional labour also refers to prevailing masculine hegemonic cultures in specific professions (such as the paramedic service) which socialise individuals to suppress and control their emotions. Examples of societal and cultural expectations around emotional expression and need to suppress and control one's emotions emerged as an overarching theme in Williams' (2013a, 2013b) study with paramedic students. Williams (2013a, 2013b) highlights that the suppression and control of emotions in the paramedic service can partly be attributed to the prevailing hegemonic masculine culture which socialises paramedics to suppress their emotions. The paramedic students interviewed by Williams (2013a) indicated that they were expected to 'deal with it', 'to cope', 'to shut off' or 'shut down' their emotions.

### **Intrapersonal Emotional Labour**

This reoccurring theme across the professional groups relates to some of the challenges of employing emotional labour in managing one's own emotions and those of others. Several authors acknowledge that managing distress, suffering, trauma, death, bereavement,

anxiety and anger, for example, were a common source of emotional labour for many participants (Williams 2013a, Williams 2013b, Bolton 2000, Gray & Smith 2009). Some authors identified examples of emotional labour or emotion management as unhelpful and potentially stressful for professionals (Smith & Kleinman 1989, Hunter 2013b). For example, in interviews with paramedic students, Williams (2013a, 2013b) found that paramedic students often controlled or suppressed emotions and sometimes struggled to manage their emotions and those of their patients and carers. The implications of these approaches to emotion management are discussed in more depth in the final theme of ‘support and training needs’.

Likewise, from their observations of and interviews with medical students, Smith and Kleinman (1989) also identified the ways a range of emotionally distancing strategies were employed by medical students to cope with unsettling situations. Examples of this include de-sensitisation strategies, such as excluding psychosocial aspects of patients’ worlds (feelings, values, and social context), and using the cloak of biomedicine as a distancing strategy or defence against difficult feelings. The latter involved an (over) reliance on the rationality and objectivity of western medicine to distance themselves from difficult feelings. The authors also observed that medical students used derogatory humour to de-humanise their patients as a strategy to avoid difficult feelings. With the exception of this study by Smith and Kleinman (1989), there was a noticeable gap in the literature of emotional labour used in studies to understand the ways professionals, particularly doctors, managed their emotions and how this impacts on their approaches to managing the emotional dynamic that exists between the health care professional and their patient.

Weir and Waddington (2008) observed that professionals, mainly nurses, working for NHS Direct were faced with the difficulty of managing the emotions of callers when they did not have face-to-face contact with them. Other aspects of intrapersonal emotional labour relate

to those aspects which are viewed as 'positive', those that are hidden or those that may be overlooked. The identification of these aspects has brought the concept of emotional labour in a healthcare context under scrutiny by some authors (e.g. Bolton, 2000) who argue that the term underestimates and oversimplifies the motivations and altruistic nature of healthcare professionals' work. Moreover, it is argued that nursing as a profession is often associated with the satisfaction derived from caring (Rodriquez 2011, Bolton 2000).

Bolton (2000) contests the extent to which workers' feelings are commodified in a healthcare setting and suggests that some emotional labour can, to a degree, be free from organisational demands. It is argued that health professionals such as nurses have the opportunity to present their 'authentic selves' in 'unmanaged spaces', places deemed free from management control (Bolton 2000). For example, some aspects of emotional labour have been conceptualised as more of a 'gift offering' in a similar way to Hochschild's notion of 'gift exchanges' in individuals' private spheres (Hochschild 2003). This includes nurses who appear to go beyond the call of duty to provide care and compassion to patients who are in distress, such as when supporting women who are grieving for the loss of their babies through late miscarriages or late terminations (Bolton 2000).

Similarly, care home workers also indicated that they derived more satisfaction when they had the opportunity to develop more intimate relationships with care home residents. However, this was often constrained by the economic drivers of care homes which devalued the importance of caring and therapeutic relationships (Rodriquez 2011). Care workers also appeared to go beyond the call of duty to enact caring in both salient and subtle ways, hereby deriving satisfaction from their work whilst retaining their emotional integrity. One such example involved a nurse sending a resident's favourite pillow to him during his dying



days in hospital, for which the resident and family communicated their gratitude (Rodriquez 2011).

The positive aspects of emotional labour in the workplace may also have been overlooked. One such example, observed by Bolton (2000), is the way nurses employ humour as a way of managing emotions on a gynaecology ward. Humour enabled nurses to manage their emotions in an environment that could be charged with a range of complex and challenging emotions, such as grief, frustration, or anger, according to Bolton (2000).

Theodosius (2006) argues that there are considerable unconscious processes taking place in the way nurses manage their emotions which are often hidden from the emotional labour lens and require the judicious use of methods to capture these. Theodosius employed diaries to capture hidden, unconscious emotion processes to manage emotions such as guilt, anger and frustration. When these hidden aspects of emotional labour are revealed through the use of diaries, for instance, they reveal a more complex picture in terms of how emotional labour is employed behind the scenes. Theodosius gives an example of a nurse who suppresses feelings of disgust or anger towards a patient to communicate sympathy - a more socially acceptable, desirable and expected emotional offering. Theodosius therefore argues that such aspects of emotional labour, often requiring 'deep' acting, frequently remain hidden and more likely to be taken-for-granted.

### **Collegial and Organisational Sources of Emotional Labour**

This theme relates to the way emotional labour is employed to support relationships and manage conflicts with colleagues and organisational hierarchy. Miller *et al.* (2009) identified that nurses' emotional labour in this area was often taken-for-granted by doctors,

which frequently led to disengagement and inter-professional conflict. Rodriquez (2011) identified tensions arising between care home workers and institutional financial drivers which devalued the investment of emotional labour required to build relationships and emotionally connect staff and residents. The institution valued medical care above psychosocial care and the accompanying emotion work required to build and maintain relationships to meet the psychosocial needs of residents. Staff responded or resisted such demands by valuing emotional attachments between their selves and residents to preserve their sense of integrity and dignity in the work place.

The findings of the Rodriquez study highlight that staff resist institutional financial drivers that do not reward emotional labour by continuing to invest in relationships and by valuing the importance of emotional connectedness with care home residents. These findings contrast with Hochschild's original theory which posited that workers' feelings could be commodified in an organisational setting – that workers' feelings could be bought or influenced by the demands and dictates of their employers. The findings of the above study suggest that workers in a healthcare setting may resist institutional demands which do not reward or encourage emotional labour. Rather, staff valued emotional labour over and above the demands of their employers. The authors identified that in doing so, workers maintained their self-respect and sense of integrity in the workplace.

Organisational conflict also arose when professionals felt unsupported or when their emotional labour was taken-for-granted. For example, Weir and Waddington (2008) observed that nurses experienced discord derived from feeling unsupported by their managers in NHS call centres (NHS Direct). Nurses felt unsupported as they perceived that managers were detached from the emotional demands of their work.

In one study, midwives experienced conflict arising from competing ideologies held in midwifery (Hunter 2005). Hunter (2005) observed conflict amongst junior and senior midwives. Such disharmony emerged from ideological conflicts and stress arising from emotional dissonance in midwives who had difficulty working to a biomedical model of midwifery when they were ideologically orientated and committed to a community model. The community model focuses more on the psychosocial needs and wellbeing of women and their families and was therefore at odds with the rationalist underpinning and disembodied approach of the biomedical model which junior midwives encountered in hospitals (Hunter 2004).

Through the combined use of observation and reflective diaries, Theodosius (2006) was able to reveal the relational and dynamic aspects of emotional labour in the workplace. Theodosius argues that the varying sources of emotional labour do not arise in an interactional vacuum; they occur between patients and other workers albeit through conscious and unconscious processes. These methods were able to identify how emotional labour was employed to manage conflict with colleagues which arose during the day-to-day work of hospital nurses.

### **Support and Training Needs**

The final theme relates to authors' identification of the need for organisations to provide adequate support and training to professionals to enable them to manage the emotional demands of their work. In terms of future work in the area of emotional labour and healthcare, some authors call for emotional labour to be made more explicit in terms of identifying the range of work that is carried out. In this way, emotional labour can be made explicit rather than taken-for-granted, as an assumed aspect of a professional's role for

which training and support are often overlooked (Williams 2012, Gray & Smith 2009, Staden 1998). Some authors call for a 'politicisation of caring' to ensure emotional labour is recognised and valued (Gattuso & Bevan 2000, Staden 1998).

In contrast to a critique of emotion work as woman's work, nurses in Staden's (1998) study perceived emotional labour to be a life skill, acquired through life experience. The views of these nurses would seem to support common assumptions around emotional labour as a 'natural' skill which is consequently more likely to be overlooked and undervalued, particularly in the nursing professions where women still predominate.

## **Discussion**

This review identified the varying professional, gendered, personal and socio-cultural sources of and barriers to emotional labour. The first theme highlighting the focus of emotional labour research on the nursing and midwifery professions is likely to be linked to gendered aspects of emotional labour - a critique of emotion work as women's work. This theme highlights how a prevailing masculine hegemonic culture can influence expectations around gendered aspects of emotional labour and ways professionals are socialised to manage their emotions, principally by suppressing or controlling their feelings. Feminist theory, the principle underlying theory of Hochschild's original work, is valuable in understanding how socio-cultural feeling rules operate in the workplace and how prevailing cultures influence the suppression and expression of emotions.

The focus of emotional labour research on the nursing and midwifery professions may reflect assumptions and expectations around the gendered aspects of emotional labour and the role or capability of nurses to undertake or engage in emotional labour. It has been argued that the focus on nursing and lack of focus on doctors, for instance, may reflect

socio-cultural feeling rules or expectations relating to the professionalisation of emotion, influencing who can/should provide emotional labour (Larson & Yao 2005). Greenberg *et al.* (1999), for instance, reported that doctors attach little importance to empathy while other factors, such as workload and insufficient training in the area of emotion management, may influence the ways doctors engage with their patients on an emotional level. Another study by Smith and Gray (2000) reported that doctors frequently perceived emotional labour to be within the remit of nurses' work, while nurses perceived that doctors often left them to 'pick up the emotional pieces' (Smith & Gray 2000 p. 49).

Such findings may highlight the continued divisions of emotional labour between the nursing and midwifery professions, where women still predominate and the medical professions. These divisions often lead to inter-professional conflict, requiring additional emotional labour to manage inter-professional relationships. It will therefore be useful to reflect on how gendered aspects of emotional labour may be influenced by the increasing numbers of women entering medicine (GMC 2012).

In the 'caring' professions, emotional labour has been defined as the way the worker or professional may be expected, from an organisational, personal/professional or societal standpoint, to manage emotional performances which can require considerable effort and engagement with their patients (Smith 2012). While this is not contested by authors across the studies, some researchers have questioned the application of aspects of Hochschild's thesis to the healthcare setting and in doing so have drawn attention to the more complex, sometimes hidden and dynamic aspects of emotional labour: that satisfaction can be gained by offering emotional labour and that additional satisfaction is derived from the ways it is valued by patients (Rodriquez 2011, Bolton 2000).

The use of emotion work theory in a health care setting has advanced the application of Hochschild's commodification thesis and its relevance to health and social care settings

such as the NHS or care homes. Authors (Rodriquez 2012, Theodosius 2008, Bolton 2000, Staden 1998) have questioned the extent to which workers' feelings are owned or influenced by the demands of the institutional setting by highlighting that health care workers gain satisfaction from caring. Additionally, rather than depicting emotional labour as a unilateral offering, the authors highlight the reciprocal aspects of emotional labour – that both patients and workers derive satisfaction from offering emotional labour.

However, counter arguments suggest that when emotional labour occurs in any organisational setting, such as a hospital, the worker can never truly be free from organisational demands placed on their emotional selves (Brook 2009). While it could be argued that workers can never be free from the institutional constraints, evidence suggests that staff resist the organisational devaluing of emotional care to continue to derive meaning and satisfaction from their work (Rodriquez 2011). It is argued that in these scenarios, where emotional labour remains hidden and is often conducted 'behind the scenes', organisations may be profiteering from the non-financial rewards (such as job satisfaction, emotional gratification) derived from caring (Folbre 2001).

Emotion work theory makes a valuable contribution towards a more critical understanding of the employment of emotional labour in a healthcare setting. It questions assumptions around the gendered and hidden aspects of emotional labour – including intrapersonal emotional labour employed to manage challenging situations such as collegial and organisational conflict. By revealing and making explicit the range of emotional labour undertaken by professionals, it may enable this work to be recognised and more highly valued. Moreover, it is argued that when emotion work is 'privatised', managed intrapersonally both in and beyond the institutional setting, organisations are consequently freed of their responsibility to provide care and support to their workers (Boyle 2002). Consequently, by making emotional labour explicit, it is hoped that organisational

responsibilities regarding the provision of suitable training and support, will be offered to health care professionals to enable them to respond and manage their feelings, more effectively. This is valuable given the increasing levels of stress and burnout experienced by healthcare workers and reported lack of infrastructure in some healthcare settings (i.e. the NHS) to support staff to manage the emotional demands of their work (Sawbridge & Hewison 2013). Consequently, the need for dedicated policies and care pathways for healthcare professionals is paramount in addressing these concerns.

The findings have also highlighted the effect of socio-cultural feeling rules on the division of emotional labour amongst some professional groups, such as the emotional distancing strategies of medical students and paramedics. It should be noted that the majority (N=9) of these studies took place in the NHS setting in the UK and therefore the application of the review findings to other locations may be less generalisable. The articles included in this review have advanced the application of emotion work theory to the healthcare setting while acknowledging emotional labour as a more dynamic and transactional encounter where the emotional challenges and rewards are experienced by both staff and patients.

## **Conclusion**

This review highlights the range of ways emotional labour is employed by health care staff in managing their own emotions arising from caring for and interacting with patients and their relatives. Emotion work was also employed in managing relationships with colleagues and in dealing with ideological and organisational demands, differences and conflict. The review highlights that the organisations may often overlook or take-for-granted the emotional labour involved in caring. In some institutional settings (such as private care homes), the financial drivers may conflict with the motivations of workers who

derive satisfaction from caring; in such a situation, organisations could be exploiting the 'good will' of their workers.

The review highlights the need for and importance of putting support and supervision in place to enable staff to cope with the varied emotional demands of their work. The applicability of emotion work theory in a healthcare context has also raised important considerations about the value of emotional labour to both staff and patients in terms of reciprocal gain. Emotion work theory can also illuminate the emotional cost of caring in different organisational settings. Future research can capitalise on these developments and can usefully be extended to other settings (community settings and primary care) and to other health workers (such as doctors, health visitors, reception staff) to shed light on the emotion work requirements and support which may be required in other settings. In understanding the gendered, personal, professional and cultural barriers to emotion work, it may also contribute to our understanding of factors affecting stress and burnout and retention problems in healthcare settings.



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Table 1: A summary of papers identified for the thematic view of emotional labour in a healthcare setting

<i>Study</i>	<i>Sample and Setting</i>	<i>Aim, Design and Analysis</i>	<i>Limitations</i>
Williams (2013a), UK	8 second-year undergraduate paramedic students (6 male; 2 female). Paramedic service.	To explore and examine paramedic students' perceptions and experiences of emotion work and the strategies used to deal with it. A qualitative, exploratory design, semi-structured interviews. Thematic content analysis	Small sample size with no justification for numbers (i.e. data saturation) - may limit conclusions drawn about gendered aspects of emotion work; sampled from one institution, limiting generalisability.
Williams (2013b), UK	8 second-year undergraduate paramedic students (6 male; 2 female). Paramedic service.	To identify and explore emotion work within student paramedic practice. A qualitative, exploratory design using semi-structured interviews. Thematic content analysis	As per previous paper (Williams, 2013a) as derived from same study.
Rodriguez (2011), US	Nursing care workers. One private nursing home.	No stated aim/objective for the study. Emotion work is referred to throughout, including the abstract, introduction and study design. Participant observation and 65 interviews with staff. Grounded theory.	No aim/objectives. Lack of transparency in analytic process, no reference to reflexive process; limiting dependability of the findings
Gray & Smith (2009), UK	16 qualified, practicing nurses within primary care, mental health and children's oncology. 12 female, 4 male; ethnically diverse sample.	To identify the experiences of nurses in relation to their feelings and emotional labour. 16 in-depth and semi-structured interviews. A participatory and reflective research focus. Ethnographic approach underpinned by feminist traditions. Thematic analysis.	Only 4 male participants, limiting generalisability concerning gendered aspects of emotion work.
Miller <i>et al.</i> (2008), Canada	Nursing, medical and allied professionals, general internal medicine wards in 3 hospitals in urban settings.	To examine nursing emotional labour and inter-professional collaboration. Qualitative data using non-participant observation, shadowing and 50 semi-structured interviews with staff. Content analysis.	Settings limited to 'internal medicine' wards in acute care teaching hospitals, limiting generalisability to other healthcare settings.
Weir & Waddington (2008), UK	36 call handlers, healthcare staff and assistants working in NHS direct. National Health Service Direct (NHS Direct).	Exploring the experience and emotional labour of nurses working in a call centre (NHS Direct). Single site case study, qualitative ethnographic approach using non-participant, naturalistic observation and in-depth interviews. Thematic analysis.	No breakdown of staff characteristics including position of staff and demographic information. Restricted to one call centre. No theoretical framework stated; no inter-coding. No reference to reflexive process.

Theodosius (2006), UK	Staff nurses. An acute surgical ward in an NHS hospital.	To identify hidden and visible emotion processes in order to understand how they impact on emotional labour. 14 months of participant observation, 15 audio diaries and semi-structured interviews. Narrative analysis and analysis using psychoanalytic tools.	No description of participant characteristics. Only one ward observed, limiting generalisability. One coder, limiting the 'trustworthiness' of the research findings.
Hunter (2005), UK	27 student midwives and 10 hospital-based midwives in a NHS Trust.	To identify and explore the emotional labour of hospital-based midwives. An ethnographic approach using focus groups, observations and interviews. Theoretical framework of 'boundary maintenance' was used to undertake analysis.	Accounts limited to junior midwives' accounts and therefore counter or alternative narratives derived from senior midwives are limited.
Hunter (2004), UK	27 student midwives, 11 qualified midwives, 29 midwives in one NHS Trust.	To explore how a range of midwives experienced and managed emotion in their work. A qualitative study, ethnographic approach - focus groups, observations and interviews. Thematic analysis.	Limitations as per previous study (Hunter, 2005) as data derived from same study. Generalisability limited to homogenous sample in terms of grade of midwife (junior), ethnicity (predominantly white) and gender (all female).
Bolton (2000), UK	Gynaecological nurses working in gynaecological wards and in outpatient clinics, NHS Trust.	To learn how nurses feel the introduction of 'new' management has affected their work. Emotion work theory underpins the study. A qualitative study, semi-structured interviews and observation. Thematic analysis.	Number of interviews and characteristics of participants not stated. Analytic framework not explicit. Generalisability limited to gynaecological wards.
Gattuso & Bevan (2000). Australia	Nurses practicing in aged-care nursing, care home and community and district nursing roles.	To examine emotional labour within the predominantly female environment of aged-care nursing. Focus groups (N=16).	A convenience sample from a few care homes thereby limiting generalisability. Method of analysis, not stated. No reference to reflexive process.
Staden (1998), UK	Three experienced enrolled nurses (level 2). NHS setting in a hospice, mental health ward, and haematology ward.	To recognise and value emotional labour and the skills involved and embodied within it. Case studies, semi-structured interviews. Phenomenological analysis.	Sample size of three may limit generalisability.
Smith & Kleinman (1989), US	Medical students and other staff (residents and consultants) nurses, spouses, hospital counsellor). Hospitals	To examine how students manage emotions and learn to handle unsettling reactions to patients and procedures. Participant observation of 1 <sup>st</sup> -3 <sup>rd</sup> year students and 64 in-depth interviews. Thematic analysis.	Sampling from one institution. Emotion work is not explicitly referred to in design, reference to emotion management

Figure 1: Flow Diagram of Literature Search Results



